

## CONSENT TO RELEASE MEDICAL INFORMATION

Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

**Physician releasing records:**

**Physician/person to receive records:**

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

City \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**Medical information to be sent:**

\_\_\_\_\_ Entire Medical Record, **INCLUDING** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

\_\_\_\_\_ Entire Medical Record, **EXCLUDING** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

\_\_\_\_\_ Record of care from \_\_\_\_\_ to \_\_\_\_\_ **INCLUDING** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

\_\_\_\_\_ Record of care from \_\_\_\_\_ to \_\_\_\_\_ **EXCLUDING** information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

This applies to all information in my medical record protected under the regulations in 42 Code of Federal Regulations, Part 2.

I authorize medical information to be released as indicated above. I understand this release is effective until \_\_\_\_\_, but that I may revoke my consent at any time by providing written consent to the above named party.

\_\_\_\_\_  
Patient or Patient's Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date